

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-006616

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

149

Primary Registration District No.

1002

Registrar's No.

1318

STATE FILE NUMBER

FILED MAR 15 1963

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY JACKSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		c. CITY OR TOWN KANSAS CITY	
Length of stay in 1b 15 YEARS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF DECEASED (If NOT in hospital, give location) HOSPITAL OR INSTITUTION RESEARCH Hospital		d. STREET ADDRESS (If outside, give location) 3027 BALTIMORE AVENUE	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First CHARLES Middle ROSS Last HAYES			4. DATE OF DEATH Month FEBRUARY Day 24 Year 1963		
5. SEX MALE	6. COLOR OR RACE CAUCASIAN	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8-12-88	9. AGE (last birthday) 74	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST			10b. KIND OF BUSINESS OR INDUSTRY		
11a. BIRTHPLACE (City and state or country) KNOX, COUNTY TENN U.S.A.			12. CITIZEN OF WHAT COUNTRY U.S.A.		
13a. FATHER'S NAME NEWTON J. HAYES			13b. MOTHER'S MAIDEN NAME HARRIET LLOYD		
14. NAME OF HUSBAND OR WIFE BERTHA HAYES			Address 3027 BALTIMORE AVENUE KANSAS CITY, MO.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 2		
17. INFORMANT Mrs. BERTHA HAYES			Address 3027 BALTIMORE AVENUE KANSAS CITY, MO.		

18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute renal failure & uremia DUE TO (b) arteriosclerosis - advanced - DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 24 HOURS YRS -
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) agranulocytosis -		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour None Month, Day, Year			

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION 104th St to 2-24-63	COUNTY Missouri	STATE Missouri
21. I attended the deceased from 104th St to 2-24-63 and last saw her him alive on 2-24-63 Death occurred at 9:25 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE [Signature]	22b. ADDRESS 104 P. V. MEDICAL BLDG. 71ST ST TO 104th St	22c. DATE SIGNED 2-25-63
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE FEB. 27, 1963	23c. NAME OF CEMETERY OR CREMATORY FOREST HILL CEMETERY
23d. LOCATION (City, town, or county) PRATTSVILLE, MISSOURI		

24. FUNERAL DIRECTOR DW Newcomer	25. DATE RECD. BY LOCAL REG. 2-27-63	26. REGISTRAR'S SIGNATURE Ruth Long
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(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK

OR

TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DATE AMENDED

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Dr. ^{Exp. 1996} ~~Exp. 1996~~ Osborn M.D.
P.R. 104 KIE Dillage Medical Bldg - 69th & Mission Road
2:00 - 5:30 PM
0 - 14
0 - 14
0 - 14

8-2-41-50

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Lenab. Michael

Licensed Embalmer No. 4340

P. O. Address K.C., Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.